NC Department of Health and Human Services – Division of Social Services
Healthcare Oversight and Coordination Plan and Psychotropic Medication Oversight Requirements

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June 2021
# Agenda

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<td>Christy Street</td>
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<td>All</td>
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Healthcare Oversight and Coordination Plan
Federal Regulations

Social Security Act  SEC. 422. [42 U.S.C. 622] (15)(A) (v) requires: The oversight of prescription medicines, including protocols for the appropriate use and monitoring of psychotropic medications;

Title IV-B Plan Health Oversight and Coordination Plan
Requirements (Effective October 7, 2008) - requires the title IV-B agency to develop ongoing oversight and coordination of health care services for children in foster care, including coordination with the state Medicaid agency. Additional information can be found at:

- The Fostering Connections to Success and Increasing Adoptions Act of 2008 (Public Law (P.L.) 110-351)
- ACF- Log No: ACYF-CB-PI-09-06  Issuance Date: June 3, 2009
- ACF- Log No: ACYF-CB-PI-10-09  Issuance Date: April 20, 2010
- ACF- Log No: ACYF-CB-PI-10-10  Issuance Date: June 7, 2010
- ACF- Log No: ACYF-CB-PI-10-11  Issuance Date: July 9, 2010
- ACF- Log No: ACYF-CB-IM-12-03  Issuance Date: 04-11-2012
- ACF- Log No: ACYF-CB-PI-13-04  Issuance Date: April 10, 2013
- The Child and Family Services Improvement and Innovation Act (P.L. 112-34)
- Family First Prevention Services Act of 2018
NC Health Care Oversight and Coordination Plan 2020-2024

• The Health Care Oversight and Coordination Plan (HOCP) affords states the opportunity to integrate numerous federal health requirements for children/youth in foster care into a comprehensive plan.

• The activities contained within this plan are designed to improve individual child/youth health outcomes and strengthen the child welfare system’s ability to achieve safety, permanency, and well-being for all children.

• The plan is developed in collaboration with stakeholders and helps states to develop plans that use federal funding effectively and secures positive outcomes for the children and families it serves.

• Requires a plan for the oversight and monitoring of psychotropic medications.

  • Target 3 of the Health Care Oversight and Coordination Plan: Strengthen Protocols for Monitoring of Psychotropic Medications at the Local Agency Level - North Carolina will review and update protocols, guidance, training, and resources to provide clarity to the child welfare workforce, the medical community, and resource parents to properly execute medication oversight and monitoring at the local agency level.
Available Mechanisms and Strategies to Support the Oversight and Monitoring of Psychotropic Medications

• The Medical Home Model
• Community Care of North Carolina (CCNC) and Care Management for at Risk Children (CMARC) Care Management
• Child Health Summary Forms
• FHNC Online Resource Library
• FHNC Medication Workgroup
• A+ KIDS
• OSRI
• Policy guidelines require foster parents to maintain a Medication Administration Record (MAR)
• Community Pharmacy Enhanced Services Network
• NC Psychiatry Access Line (NC-PAL)
Child Welfare Policy Changes and Guidance

Policy Change
For children and youth in foster care receiving psychotropic medications, agencies must;
• Refer and coordinate services for all children in foster care who receive psychotropic or other high alert medications included in the Best Practices for Medication Management for Children & Adolescents in Foster Care to care management through Community Care of North Carolina (CCNC) within 7 days and request a medication reconciliation from the CCNC Care Manager.

Guidance
To refer children and youth in foster care to care management with CCNC, Child Welfare Staff will complete the **CCNC Custody Status Notification Form** available at https://www.ncpeds.org/page/FHNCLibrary and fax the document to CCNC at 833-282-0884.
Practice Change - Monitoring During Permanency Planning Monthly Visits and Documentation on DSS 5295

- **Current Prescribed Medication(s)**

<table>
<thead>
<tr>
<th>Child/Youth</th>
<th>Prescribed Medication(s)</th>
<th>Dosage</th>
<th>Prescriber</th>
<th>Side Effect Concerns (weight, appetite, alertness or other conditions)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

*For each child/youth listed above:*

Are there any changes to prescribed medications? If so, what warranted the change?

*If there are side effect concerns noted, a referral to Care Management, or follow-up with current care manager for a Psychotropic Medication Reconciliation must be requested within 72 hours. Urgent concerns should be immediately reported to the prescriber.*
NC FAST Counties

The changes in NC FAST will occur within the next few months - when this occurs, a new Dear County Director Letter (DCDL) will be sent notifying counties.

Until this occurs, counties using NC FAST please use the free text narrative field labeled “Narrative” (step 6) the Contact Log for Monthly Permanency Planning Contact Record to record the information for prescribed medications, for each child on the Ongoing Case.
Why Are These Changes Needed?

- One in four children in foster care between ages 6 and 17 are administered at least one psychotropic drug.
- A significant number of children are given a combination of two, three, or four drugs at the same time.
- Prevalence of mental health diagnoses for children and youth in foster care creates more likelihood medication will be prescribed.
- To ensure the monitoring of medication regimens for potential side effects and health risks.
- To ensure that appropriate screening, diagnosis, and therapeutic interventions are occurring.
- To increase the awareness and utilization of resources to support child welfare workers to ensure the children and youth in care are being prescribed medications safely and within accepted parameters.

Figure 1. Rates of Major Mental Health Diagnoses Among Medicaid-Enrolled Children in Foster Care by Age (6 to 11 years and 12 to 18 years), 2002 and 2007

Source: Figure prepared by the Congressional Research Service (CRS) based on data from David Rubin et al., "Interstate Variation in Trends of Psychotropic Medication Use Among Medicaid-enrolled Children in Foster Care," Child and Youth Services Review, Vol. 34, No. 8, 2012, p. 1492.

https://www.everycrsreport.com/files/20170217_R43466_62d2a80968fb095760b70f326e1932be457cee0d.pdf
Figure 2. Share of Children in Foster Care (Ages 16 Months to 19 Years Old Who Met Clinical Criteria for a Mental Health Need) and Their Use of Psychotropics and Specialty Mental Health Services

Percentages based on caregiver reports at time of interview or youth self-report for those 18 or older

- 33.1% Psychotropics and specialty mental health services
- 30.0% No specialty mental health services or psychotropic medications
- 27.5% Specialty mental health services only
- 9.4% Psychotropic medications only


https://www.everycrsreport.com/files/20170217_R43466_62d2a80968fb095760b70f326e1932be457cee0d.pdf
### Table A-1. Use of Psychotropic Medication Among Children in Families Investigated for Child Abuse or Neglect

Percentages based on caregiver report at time of interview or youth self-report for those 18 or older

<table>
<thead>
<tr>
<th>Age at Time of Survey and Placement Status of Children</th>
<th>4 to 6 Months Following Investigation</th>
<th>18-Month Follow-Up</th>
<th>36-Month Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL (18 months or older)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foster Care</td>
<td>15.9%</td>
<td>23.1%²</td>
<td>32.8%²</td>
</tr>
<tr>
<td>In-home</td>
<td>11.6%</td>
<td>11.0%</td>
<td>12.9%</td>
</tr>
<tr>
<td>Ages 18 months to 5 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foster Care</td>
<td>3.7%</td>
<td>1.5%</td>
<td>8.8%</td>
</tr>
<tr>
<td>In-home</td>
<td>1.4%</td>
<td>1.6%</td>
<td>1.6%</td>
</tr>
<tr>
<td>Ages 6-10 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foster Care</td>
<td>21.3%</td>
<td>37.0%²</td>
<td>27.6%</td>
</tr>
<tr>
<td>In-home</td>
<td>19.5%</td>
<td>19.2%</td>
<td>16.1%</td>
</tr>
<tr>
<td>Ages 11-17 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foster Care</td>
<td>26.8%</td>
<td>39.9%³</td>
<td>47.0%³</td>
</tr>
<tr>
<td>In-home</td>
<td>15.7%</td>
<td>13.8%</td>
<td>16.5%</td>
</tr>
<tr>
<td>Age 18 or older</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Include all youth age 18 or older regardless of where they lived.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Source:** Congressional Research Service, based on data from NSCAW II as received from the U.S. Department of Health and Human Services, Administration for Children and Families, Office of Planning Research and Evaluation (OPRE), January 2014.

https://www.everycrsreport.com/files/20170217_R43466_62d2a80968fb095760b70f326e1932be457cee0d.pdf
Fostering Health NC (FHNC)

Who are we and what do we do?

- A program of the NC Pediatric Society – funded by the Division of Social Services

- Focus is on helping improve the health and well-being of children and youth in foster care through integrated communications and coordination of care

- We do this by:
  - Providing education and training on health and well-being
  - Bringing key stakeholders together to problem solve, brainstorm, etc...
  - Facilitating & convening meetings
  - Providing technical/support assistance
  - Assisting Division of Social Services with review/revisions to HOCP
The **medical home model** is a comprehensive approach to primary care, ensuring that all of a child/youth's medical and non-medical needs are met through a unique partnership involving the pediatric care team, the child/youth and the child's family.

The medical home is a particularly good fit for children in **foster care**, whose families include foster and birth families, because of its emphasis on coordination and comprehensive care. Children in foster care suffer a higher incidence of problems with physical, behavioral, and oral health than any other group of children.

**Children/youth in foster care**, *no matter how healthy they seem*, are considered Children and Youth with Special Health Care Needs because of exposure and experience of trauma – requiring specialized care.

Aspects of a medical home:
- Continuity of care
- Same practice, ideally same provider
- Communication
- Collaboration
- Team approach – includes those staff in the practice and others outside of practice – the child, you as a resource/foster parent, county DSS staff, biological parent(s), private agency, care management agency, etc...
# Core Components of a Foster Care Medical Home

## Primary Care Physician
- Designate a foster care contact & scheduler
- Hold standard # of “acute” visits/week to accommodate initial foster care visits
- Schedule comprehensive visit within 30 days of custody
- Review records prior to Comprehensive visit
- Adopt AAP schedule for Follow-up Well-Visits, incorporating priorities of social-emotional development screening for Children and Youth with Special Health Care Needs (CYSHCN)
- Complete associated Health Summary Forms

## County DSS
- Designate foster care contact
- Assure youth is enrolled in a CCNC Network practice
- Designate staff to use Virtual Health Provider Portal for background on each child entering care
- Gather medical history
- Complete health history form (prior to 30 day comprehensive appointment)
- Refer all children/youth to CMARC (0-5) or CCNC (5 & older) for care management

## Care Management
- Designate foster care contact
- Arrange Virtual Health Provider Portal access for DSS designee
- Assure communication & coordination occurs when a child is placed out of region
- Assure health information is shared with PCP, DSS, and foster and biological parent
- Provide ongoing care management services
- CCNC & CMARC work with foster family and biological family (if reunification is the permanent plan)
American Academy of Pediatrics Guidelines

AAP Recommendations/Guidelines:

• Initial Health screening visit within 72 hours
• Comprehensive Health Visit within 30 days of placement
• Follow-up health visit within 60-90 days of placement & following enhanced visit schedule

Enhanced visit schedule:

• Visits monthly: 0-6 months old
• Visits every 3 months: 6-24 months old
• Visits twice per year: 2-21 years old

www.aap.org/fostercare
Relevant DSS Forms

- Health Summary Forms
  - Health Summary Form - Initial Visit (DSS-5206)
  - Health History Form (DSS-5207)
    - Completed by DSS Social Worker – provided to medical home and foster parent prior to the comprehensive visit appointment
  - Health Summary Form - Comprehensive Visit (DSS-5208)
  - Health Summary Form - Well Visit (DSS-5209)

- DSS-1812 – General Authorization for Treatment and Medication
  - Some things require the biological parent(s) consent (or court order)
  - Whenever possible, county child welfare agencies should work with parents to address foreseeable non-routine care and treatment needs of the child prior to the 7-Day Nonsecure Custody Review Hearing. If no parent is able or willing to authorize the county to provide consent, the county child welfare agency should ask the court for authority to consent to and arrange for care and treatment in the child’s best interest.
Oversight and monitoring is crucial for children/youth who are prescribed medications, especially psychototropic medications.

**Management must be a team effort involving:**
- Provider/Prescriber (primary care doctor, psychiatrist, specialist)
- DSS/Child Welfare Worker
- Foster/Resource Parent(s)
- Pharmacist
- Care Manager
- Private Agency Staff
- Child/Youth
Medication Oversight and Monitoring

Resources:

- Fostering Health NC Resource Library
  www.ncpeds.org/fosteringhealthnc

  - “Best Practices for Medication Management for Children and Adolescents in Foster Care”

  - “Guide for Use and Monitoring of Psychotropic Medications in Children and Adolescents”

- North Carolina Psychiatry Access Line (NC-PAL)
- Care Management
Medication Oversight and Monitoring

“Best Practices for Medication Management for Children & Adolescents in Foster Care”

• Key Information and Resources

• High Alert Medication Review Guidelines

• Red Flag Medication Review Guidelines

• Protocol for:
  • a Child/Adolescent who is New to Foster Care or has recently Changed Placements
  • a Child/Adolescent Already in Foster Care

• Community Pharmacy Enhanced Services Network (CPESN) Information

• Antipsychotic – Keeping it Documented for Safety (A+KIDS) Information

• North Carolina Psychiatry Access Line (NC·PAL)

• Medicaid and Health Choice Preferred Drug List (PDL)

• Questions DSS Child Welfare Workers and/or Resource Parents Can Ask Providers
“High Alert” Medication Review Guidelines - for Children & Adolescents in Foster Care

**Purpose:** To assist DSS staff with a child transitioning into foster care, or changing placements, to make sure the child has needed medication in a timely fashion to prevent adverse events as a result of being without or not taking the medication.

**Medications listed are separated into three categories:**

- Medications that can cause withdrawal symptoms if stopped abruptly (benzodiazepines, antidepressants, stimulants, Atomoxetine, opioids, baclofen, phenobarbital)
- Medications that would be risky to stop due to potential disease re-occurrence (diabetic agents, antiepileptic’s, maintenance asthma inhalers, Pancrelipase, airway clearance therapies, antibiotics, hydroxyurea, endocrine agents, antipsychotics, oral contraceptives)
- Medications that might be needed in an emergency (rescue asthma inhalers, Epi-pen®, triptans)

DSS staff should use this sheet in combination with the any available medication history or information when a child enters foster care or is moved to a different placement. If the child appears to be taking any of these classes of medications consistently within the past 60 days, DSS staff should contact the medical home as soon as possible to get these medications filled in order to prevent adverse effects.

<table>
<thead>
<tr>
<th>Condition</th>
<th>&quot;High Alert&quot; Medications (Note: List is NOT all-inclusive)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td><em>Medications that cause withdrawal symptoms if stopped abruptly</em></td>
</tr>
<tr>
<td>Diabetes (Type I and II)</td>
<td>-Insulin (Humalog, Novolog, Apidra, Lantus, Levemir, Humulin, Novolin)</td>
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<tr>
<td></td>
<td>-Glyburide</td>
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<tr>
<td></td>
<td>-Glipizide</td>
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<tr>
<td></td>
<td>-Metformin</td>
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</table>
Red Flag Medication Review Guidelines for Children & Adolescents in Foster Care

**Purpose:** To assist Prescribers, Pharmacists, and DSS Staff *(in consultation with pharmacist or prescriber)* with the identification of “Red Flag” criteria which may be potentially harmful to the child/adolescent while reviewing their medications.

“Red Flag” criteria indicate a need to review the child/adolescent’s clinical status in order to verify the medication regimen is accurate and appropriate. These parameters do not necessarily indicate that treatment is inappropriate, but they do indicate a need for further review. Page 13 and 14 *(Medication Management Protocols)* explain how Providers, Pharmacists, and DSS Staff can use these “Red Flag” criteria.

For a child/adolescent being prescribed a psychotropic medication, any of the following suggests the need for additional review of a patient’s clinical status:

<table>
<thead>
<tr>
<th>#1: Absence of a thorough assessment for the DSM-5 diagnosis (es) in the child/adolescent’s medical record.</th>
<th>□ YES □ NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>#2: Four (4) or more psychotropic medications prescribed at the same time (medications being prescribed to deal with the side effects of the primary medication are not included in this count (i.e., benztropine, diphenhydramine, trihexyphenidyl)).</td>
<td>□ YES □ NO</td>
</tr>
<tr>
<td>#3: Prescribing of:</td>
<td>□ YES □ NO</td>
</tr>
<tr>
<td>• Two (2) or more concomitant stimulants *, or</td>
<td></td>
</tr>
<tr>
<td>• Two (2) or more concomitant alpha agonists ‡, or</td>
<td></td>
</tr>
<tr>
<td>• Two (2) or more concomitant antidepressants §, or</td>
<td></td>
</tr>
<tr>
<td>• Two (2) or more concomitant antipsychotics ¶, or</td>
<td></td>
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<tr>
<td>• Three (3) or more concomitant mood stabilizers ¶</td>
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</tbody>
</table>

* The prescription of a long-acting stimulant and an immediate-release stimulant of the same chemical entity (e.g., methylphenidate) does not constitute concomitant prescribing.

**Note:** When switching psychotropic medications, medication overlaps (where one medication overlaps with another medication for a period) and cross taper (slowly decreasing the dose of one medication while slowly increasing the dose of another medication) should occur in a timely fashion, generally within 4 weeks.
### Red Flag Medication Review Guidelines

| P1#4: Psychotropic medications are prescribed for children of very young age, including children receiving the following medications with an age of:  
| • Stimulants: Less than three (3) years of age  
| • Alpha Agonists: Less than four (4) years of age  
| • Antidepressants: Less than four (4) years of age  
| • Antipsychotics: Less than four (4) years of age  
| • Mood Stabilizers: Less than four (4) years of age |
| □ YES □ NO |

| P1#5: The prescribed psychotropic medication is not consistent with appropriate care for the patient’s diagnosed mental disorder** or with documented target symptoms usually associated with a therapeutic response to the medication prescribed (i.e., medication isn’t usually used to treat diagnosed mental disorder or symptoms). |
| □ YES □ NO |

** See page 4 for resources that include information about clinical indications for use.  

| P1#6: Psychotropic polypharmacy (2 or more medications) for a given mental disorder is prescribed before utilizing psychotropic monotherapy (single medication). |
| □ YES □ NO |

| P1#7: The psychotropic medication dose exceeds usual recommended doses*** (FDA and/or literature based maximum dosages). |
| □ YES □ NO |

*** See page 4 for resources that include information about maximum dosages.  

| P1#8: Prescribing by a primary care provider who has not documented previous specialty training for a diagnosis other than the following (unless co-managing with a child and adolescent psychiatrist):  
| • Attention Deficit Hyperactive Disorder (ADHD)  
| • Uncomplicated Anxiety Disorders  
| • Uncomplicated Depression |
| □ YES □ NO |

| P1#9: Antipsychotic medication(s) prescribed continuously without appropriate monitoring of glucose and lipids at least every 6 months. |
| □ YES □ NO |

| P1#10: Psychotropic medication therapy for longer than 6 months without reevaluation of the need for the medication. |
| □ YES □ NO |

| P1#11: Psychotropic medication(s) prescribed without co-occurring counseling or psychotherapy. |
| □ YES □ NO |
“Guide for Use and Monitoring of Psychotropic Medications in Children and Adolescents”

- This guide includes:
  - Definition of Psychotropic Medication: Medication used in the treatment of mental illness and capable of affecting the mind, emotions, and behavior.
  - Information for child welfare workers, foster/resource parents and care managers to use when they want to learn more about a psychotropic medication:
    - Therapeutic class
    - Brand and generic names,
    - FDA approved uses,
    - Common evidence-based uses,
    - Potential side effects
    - Medication-specific safety/effectiveness monitoring
  - A color-coded quick reference guide for each medication
  - Questions that a foster/resource parent should ask a prescriber
  - Glossary of terms

www.ncpeds.org/fosteringhealthnc
“Guide for Use & Monitoring of Psychotropic Medications in Children & Adolescents”

<table>
<thead>
<tr>
<th>Appendix A: Psychotropic Medications</th>
<th>Match the Color or Number with the Therapeutic Class Above</th>
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</thead>
<tbody>
<tr>
<td>Dexedrine, Zenzedi (1)</td>
<td>Mirtazapine (2)</td>
</tr>
<tr>
<td>Dexamethasone (1)</td>
<td>Olanzapine (3)</td>
</tr>
<tr>
<td>Dextroamphetamine (1)</td>
<td>Oxcarbazepine (4)</td>
</tr>
<tr>
<td>Diphenhydramine (5)</td>
<td>Paliperidone (3)</td>
</tr>
<tr>
<td>Divalproex Sodium (4)</td>
<td>Paroxetine (2)</td>
</tr>
<tr>
<td>Duloxetine (2)</td>
<td>Paxil (2)</td>
</tr>
<tr>
<td>Escitalopram (2)</td>
<td>Pristiq (2)</td>
</tr>
<tr>
<td>Effexor, Effexor XR (2)</td>
<td>Prozac (2)</td>
</tr>
<tr>
<td>Eskalith, Eskalith CR, Lithobid (4)</td>
<td>Quetiapine (3)</td>
</tr>
</tbody>
</table>

**Key:**

- ADHD medications – (1) - YELLOW
- Depression & Anxiety Medications – (2) - BLUE
- Second Generation Antipsychotic Medications - (3) - RED
- Mood Stabilizer Medications – (4) - GREEN
- Sleep Medications (5) - PURPLE
“Guide for Use and Monitoring of Psychotropic Medications in Children and Adolescents”

<table>
<thead>
<tr>
<th>Appendix A: Psychotropic Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Match the Color or Number with the Therapeutic Class Above</td>
</tr>
</tbody>
</table>

| Ability (3) | Eszopiclone (5) | Quillinant XR (1) |
| Adderall, Adderall XR (1) | Fanapt (3) | Ramelteon (5) |
| Amphetamine Mixed Salts (1) | Fetzima (2) | Remeron (2) |
| Anafranil (2) | Fluoxetine (2) | Rexulti (3) |
| Aptensio XR (1) | Fluvoxamine (2) | Risperdal (3) |
| Aripiprazole (3) | Focalin, Focalin XR (1) | Risperidone (3) |
| Asenapine (3) | Geodon (3) | Ritalin, Ritalin SR/LA (1) |
| Atomoxetine (1) | Guanfacine (1) | Rozerem (5) |
| Benadryl (5) | Hydroxyzine (5) | Saphris (3) |
| Brexpiprazole (3) | Iloperidone (3) | Seroquel, Seroquel XR (3) |
| Brilinta (2) | Invega (3) | Sertraline (2) |
| Bupropion (2) | Lamictal (4) | Strattera (1) |
| Carbamazepine (4) | Lamotrigine (4) | Tegretol, Tegretol XR, Epito1, Carbatrol, Equetro (4) |
| Cymbrex, Capway (1) | Latuda (3) | Tenex, Intuniv (1) |
| Celexa (2) | Lexapro (2) | Trazadone (5) |
| Citalopram (2) | Levomilnacipram (2) | Trileptal (4) |
| Clonipramine (2) | Lisdepamifetamine (1) | Trintellix (2) |
| Clonidine (1) | Lithium (4) | Venlafaxine (2) |
| Clozapine (3) | Lonesta (5) | Vibryl (2) |
| Clozpare, FazaClo, Versacloz (3) | Lurasidone (3) | Vilazodone (2) |
| Concerta (1) | Luvox (2) | Vistaril, Atarax (5) |
| Cymbalta (2) | Melatonin (5) | Vortioxetine (2) |
| Depakote, Depakote ER. | | |
## Guide for Use & Monitoring of Psychotropic Medications in Children & Adolescents

### Second Generation Antipsychotic Medications (3)

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Brand Names</th>
<th>FDA Approval Age/Indication</th>
<th>Other Common Uses in Children</th>
<th>Potential Side Effects</th>
<th>Monitoring Needed</th>
</tr>
</thead>
</table>
| Aripiprazole | Abilify     | • 10 and older - for bipolar disorder, manic or mixed episodes.  
• 13 to 17 - for schizophrenia and bipolar disorder.  
• 6 to 17 for irritability associated with Autism Spectrum Disorder | All Second Generation Antipsychotic Medications:  
-Irritability and aggression in Disruptive Mood Dysregulation disorder;  
Oppositional Defiant Disorder;  
Conduct Disorders;  
Depression with psychotic features. | • Acute Extrapyramidal symptoms (drug-induced movement disorders)  
• Tardive dyskinesia  
• Neuroleptic malignant syndrome (characterized by fever, altered mental status, muscle rigidity, and autonomic dysfunction)  
• Hyperglycemia, diabetes mellitus  
• Elevated prolactin, gynecomastia, amenorrhea  
• Weight gain  
• Dyslipidemia  
• CBC abnormalities  
• Lowered seizure threshold  
• Dysphagia  
• Hyperthermia/lowered heat tolerance  
• Cognitive impairment (confusion and/or inability to focus that differs from baseline)  
• Clozapine - greater risk of weight gain and lipid changes | • Fasting plasma glucose or hemoglobin A1c and lipids at baseline, 3 months, then every 8 months  
• CBC- baseline and periodically  
• Blood pressure each visit  
• Pulse each visit  
• Weight/height/BMI at each visit  
• Waist circumference  
• EPS evaluation baseline and as needed  
• Tardive dyskinesia evaluation every 3 months |
| Quetiapine   | Seroquel    | • 13 and older - for schizophrenia  
• 18 and older - for bipolar disorder  
• 10 to 17 - for manic and mixed episodes of bipolar disorder | 10 to 17 - for bipolar mania  
13 to 17 - for schizophrenia | |
|             | Seroquel XR |                            |                               |                        |                   |
| Olanzapine* | Zyprexa      | • 18 and older – for schizophrenia  
• 13 to 17 - Second line treatment for manic or mixed episodes of bipolar disorder | Approved for bipolar mania or mixed episodes and schizophrenia (13-17 years) | |
|             |             |                            |                               |                        |                   |
| Risperidone | Risperdal   | • 13 and older - for schizophrenia  
• 10 and older - for bipolar mania and mixed episodes  
• 5 to 16 - for irritability associated with autism |                              | *Olanzapine – greater risk of weight gain and lipid changes |
| Clozapine*  | Clozaril    | • 18 and older | Schizophrenia |
NC Psychiatry Access Line (NC-PAL)

• NC-PAL is a free behavioral health telephone consultation program.

• Resource specialists respond to clinical questions, make referrals, and connect providers to one of our child and adolescent psychiatrists. Our board-certified psychiatry team is on hand to assist with diagnostic clarification and medication management.

• What types of questions can they help with?
  
  • Consultation on diagnoses, medications and psychotherapy interventions for a wide range of behavioral health needs (e.g. mental health care guides, screening forms)
  
  • Connection with community resources (e.g. intensive in-home providers, support groups)
  
  • Information on government programs (e.g. enrolling families for WIC, CDSA, CC4C)
  
  • Guidance on behavioral health issues, autism spectrum disorders, intellectual and developmental disabilities

• NOTE: NC-PAL consultations do not establish a physician/patient relationship with an individual patient. Providers who contact NC-PAL are responsible for providing direct care to their patients.
How does it work?

- **A provider has a question** about pediatric mental health.
- **They call NC-PAL** to get information.
- **Our behavioral health consultants respond** to questions within the scope of their expertise and can connect providers to one of our child and adolescent psychiatrists.
- **Our board-certified child psychiatry team** is on hand to assist with diagnostic clarification and medication management if necessary.

*To speak to a Behavioral Health Consultant, call:*

**(919) 681-2909**

Monday – Friday, 8 a.m.–5 p.m.

NC-PAL is not an emergency/crisis line.

*If you are in need of emergency services, please call 911 or go directly to your nearest emergency department.*
What does CCNC Care Management look like?

Care Management is provided by local, on-the-ground Care Managers in all 100 counties.

RN and SW Care Managers have access to a multidisciplinary team: physicians, psychiatrists, pharmacists and others.

Coordination between all regions, using the same documentation system.

Access to Medicaid Paid Claims, Visit history, Medication fill history

https://www.communitycarenc.org/what-we-do/clinical-programs/pediatrics/tools/foster-care
CCNC Complex Care Managers

Assess/Screen critical areas to collect data, develop and evaluate the foster child's Care Plan and goals.

- Home Transitioning: caregiver support
- School adjustment: school nurse/teachers
- Behavioral Health Management
- Medical/Dental appointment management
Behavioral/Mental Health (BH/MH)

- CCNC has Support staff that assist families in finding resources for BH/MH providers (who are approved by the foster child’s LME/MCO).

- CCNC Psychiatrists can consult with our Care Managers on complex behavioral health issues and suggest appropriate management strategies.

- CCNC staff collaborate with LME/MCO Care Coordinators in complex & crisis cases.
CCNC Care Management Collaboration Looks Like?

Collaboration: work with DSS Foster Care staff & other stakeholders to identify gaps in care and determine how best to address them, including:

- **Assess imminent medical needs, emergency appointments, medications**
- **Connect DSS to Out-of-Region Care Managers who know services and resources in the foster child placement area.**
- **Work with community stakeholders e.g. Primary Care Providers, Teacher, School SW/psychologist, CMARC Care Managers, CAP-C, etc...**

https://www.communitycarenc.org/what-we-do/clinical-programs/pediatrics/tools/foster-care
CCNC Care Management Collaboration Looks Like?

**Engagement:** Support caregivers by assisting with navigation of the medical and behavioral health systems and remove barriers to care.

- **Discuss health history with caregivers and DSS Foster Care SWs to ensure that the child’s health needs are met.**
- **Provide education on medical conditions and medications, including red flags, and devices with foster/biological parent(s) and DSS SW.**
- **Provide ongoing interactions with foster parents, DSS SW and provider to provide a focused effort to address unmet needs.**

https://www.communitycarenc.org/what-we-do/clinical-programs/pediatrics/tools/foster-care
Review and Reconciliation: CCNC Care Managers and Pharmacy team members review for medication adherence.

- Provide medication review(s) and reconciliation(s) to identify gaps in fill history, duplications, red flags, etc.
- Communicate discrepancies/needs to physicians and care team members.
- Educate families on medication and reinforce regimen

https://www.communitycarenc.org/what-we-do/clinical-programs/pediatrics/tools/foster-care
**CCNC Care Management Collaboration Looks Like?**

**Facilitate:** Ensure information flow between DSS staff, medical and behavioral health providers, and the foster and biological parents, when appropriate.

- **Notify provider when child is in Foster Care and provide placement information.**
- **Communicate issues with providers and DSS.**
- **Provide Member Action Plans (MAP) to caregivers.**

[Link](https://www.communitycarenc.org/what-we-do/clinical-programs/pediatrics/tools/foster-care)
Dental Health for Foster children

• CCNC Care Managers assist foster children and youth by providing resources to a local dentist for acute and preventative dental and oral health needs.
All foster children coming into custody as soon as possible - preferably within the first 5 days of custody

Foster children needing psychotropic medication reconciliation/review to ensure youth already established in foster care receive appropriate monitoring of psychotropic medications

When placement changes occur to support linking with needed services

Adoptions/exiting foster care/aging out of LINKs - in order to properly assist with transitions and ensure all needs are met.
How to send a referral

Submit a Custody Status Notification form

Fax: 1-833-282-0884 or Secure Email: PHOCCS2@communitycarenc.org

*We need a separate form for each child

Team approach: DSS SW, Provider and Care Manager
CCNC’s Foster Care Program

What’s expected after referral:

• DSS Case worker to help educate and notify the caregiver of the Care Management referral

• Inform the caregiver to expect a call from the Care Manager.

• Encourage the caregiver to participate in care management services.

• Care Manager, DSS Case Worker and Caregiver all communicate and work together on ongoing basis.

• Once the initial care needs are met, the CCNC Foster Care Program Manager will follow up with the caregiver/DSS Caseworker every 3 months until the child is reunified, adopted or ages out of Foster Care.
Team approach

**CCNC**

- Provide education for new or ongoing medical/mental health conditions.
- Assistance with adherence to visit scheduling the initial/30day, enhanced well child visits and dental office visits.
- Follow up with Caregivers and DSS case worker to review the child’s goals.

**DSS**

- Share historical medical/behavioral information.
- Inform CCNC of caregiver’s medical education needs.
- Collaborate with CCNC so that the CM is aware what appointments are needed.
- Follow up with the care manager when changes occur with foster child, including medication and placement changes.
CCNC Regional Foster Care Program Managers refer to:

1. **CMARC/CC4C**
   - 0-5 years old

2. **Complex Care Managers-CCNC**
   - Children 5 years and older
   - Adolescents
   *CCNC may also care manage children under 5 who are medically complex*
Foster Care Program Managers

Region 1:
Sherry Noto
P: 828-775-1203  E: snoto@communitycarenc.org

Region 2:
Delvin Campbell
P: 336-260-4760  E: dmcampbell@communitycarenc.org
Susan Vaudreuil
P: 984-365-7463  E: svaudreuil@communitycarenc.org
Counties: Alleghany, Ashe, Watauga, Wilkes

Region 3:
Brittany Bingham
P: 704-617-1232  E: bebingham@communitycarenc.org
Susan Vaudreuil
P: 984-365-7463  E: svaudreuil@communitycarenc.org
Counties: Anson, Cabarrus, Rowan, Stanly

Region 4:
Sara Owens
P: 919-896-1031  E: sowens@communitycarenc.org

Region 5:
Bobbie McLaughlin
P: 910-690-6749  E: bmclaughlin@communitycarenc.org
Counties: Harnett, Hoke, Lee, Montgomery, Moore, and Richmond
Laurie Jacobs
P: 910-523-8575  E: ljacobs@communitycarenc.org
Counties: Bladen, Cumberland, Robeson, Sampson, and Scotland
Steve Taylor
P: 910-995-8115  E: scotaylor@communitycarenc.org
Counties: Brunswick, Columbus, New Hanover, and Pender

Region 6:
Coletta Danneker
P: 252-917-2595  E: cpdanneker@communitycarenc.org

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Scenario

CCNC’s Foster Care Program Manager (FCPM) made an initial call to the foster family of a 17 yr old teen. As part of CCNC’s normal screening process, the FCPM identified medication concerns. Foster parent stated the member was on psychotropic medications: mirtazpine and sertraline (CCNC’s claims data confirmed the member had been on these medications for 6 mos) and was going to run out of medication in 2 days. There was potentially a 4-day gap before the teen could see the psychiatrist. The foster parent had requested their regular pharmacy provide an emergency fill, but they could only provide 2 days’ worth.

The FCPM contacted the CCNC Regional Pharmacist for assistance. The CCNC Pharmacist called and confirmed the child’s pharmacy had loaned a 2-day supply (2 days ago) and had sent the refill request to the provider. The pharmacy was willing to loan the patient another 2-day supply, but loaning medication causes issues with “refill too soon” rejections the next month. The CCNC Pharmacist called the provider’s office and left an urgent VM for the nurse requesting a short refill to at least bridge the patient to the upcoming appointment (4 days away). No response received.

The CCNC Pharmacist called the pharmacy back after waiting 2 hours for a return call from the practice and confirmed the pharmacy had not received a refill from the provider and requested that the pharmacy issue a one-time emergency fill allowed by the NC Board of Pharmacy for medications that can cause negative effects if doses are skipped. This solution allowed the pharmacy to bill the medication through the teen’s insurance, thus preventing the “refill too soon” issue. The medications were ready for pick up that evening, enough medication was given to get her to the scheduled psychiatrist appointment and prevented missed doses.
CCNC impact – The FCPM follow-up call was critical in helping to identify the need, and her prompt response to finding help was extremely important. The CCNC Pharmacist advocated for an urgent refill and ultimately pushed the pharmacy to issue an emergency fill which prevented missed doses. NC pharmacies are aware of the NC BOP Emergency Fill option, but it does take quite a bit of documentation and effort to complete, so it is not always the first solution. The pharmacy law and practice knowledge of the CCNC pharmacy team helps navigate a complex system and obtain the results we need for our members.
Questions
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